

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021481

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5856

FILED JUN 13 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips D. O. A		d. STREET ADDRESS (If outside, give location) 4204 E. Labadie Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Amos Middle DeShay Last		4. DATE OF DEATH Month May Day 31 Year 1963	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-25-1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Private Home	9. AGE (last birthday) 44 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. BIRTHPLACE (City and state or country) Clumbis Mississippi		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Doc Camel		13b. MOTHER'S MAIDEN NAME Lillie William	
14. NAME OF HUSBAND OR WIFE Clarence DeShay		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date) no no	
16. SOCIAL SECURITY NO.		17. INFORMANT Geneva Hughes 4204 A E. Labadie Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 331X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5:30 P to and last saw her/him alive on Death occurred at 5:30 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L Taylor Coroner		22b. ADDRESS 1300 Clark Ave.	
22c. DATE SIGNED 6-3-63 (State)		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 6-7-63		23c. NAME OF CEMETERY OR CREMATORY Washington Park	
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		24. FUNERAL DIRECTOR B.B. Kasper ADDRESS 1221 N. Grand Blvd.	
25. DATE RECD. BY LOCAL REG. JUN 3 1963		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

DATE AMENDED
2/08/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

91

VS 300
Rev. 4/59

1

2 **21**

3

4 **3**

5 **1**

6

7 **1**

8 **1**

9

10

11

12 **92-3**

13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oliver E. Crumble

Licensed Embalmer No. 5185

P. O. Address 1221 W Grand ave,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.